I N F O R M A T I O N S H E E T

FACILITY/AGENCY LICENSING REQUIREMENTS

The Bureau of Licensing - Health Facility Unit, Division of Health Systems Improvement, Utah Department of Health, licenses all health care facilities and agencies designated by Utah Code 26-21-2. The Department, through the Bureau, will issue a license when it determines that a facility/agency is in compliance with state law and applicable rules.

A facility/agency must first be licensed by the Department prior to obtaining Medicare/Medicaid certification. Certification standards may differ from State Licensure standards. Contact the Survey Manager, Bureau Medicare/Medicaid Program Certification and Resident Assessment, 288 North 1460 West, (4th floor), P.O. Box 144103, Salt Lake City, Utah 84114-4103, telephone no. 801-538-6157 for certification information.

To facilitate the licensing process, the provider should complete the following:

A. NOTICE OF INTENT.

1. Contact the appropriate city/county planning and zoning authority to determine if you are able to establish a business at the desired location.

2. Follow the plan review process for all new construction, or remodeling of an existing building to create a health care facility.

B. LICENSING ORIENTATION.

1. The prospective licensee, or a representative who will be responsible for coordinating the licensure process, must attend a licensing orientation to coordinate review of all required documents and payment of fees, PRIOR TO SUBMITTING ANY LICENSING DOCUMENTS.

2. Read the Health Facility Licensing Rules distributed at the Orientation.

3. Submit a completed "Notice of Intent" and the prelicense fee to the Bureau. THESE ITEMS MUST BE RECEIVED BEFORE ANY LICENSURE REVIEW WILL BE INITIATED.

C. LICENSURE REVIEW OF PROGRAM DESCRIPTION AND POLICY AND PROCEDURE MANUAL. Submit documents at least 90-days prior to the scheduled opening.

1. Prepare a written program description of the functions and location of the proposed facility/agency. The following shall be included: the geographic area to be served, staffing patterns, services to be offered, and other basic information relating to the facility/agency purpose.

2. The policy and procedure manual shall be typed and indexed. The manual shall address the standards and requirements set forth in the Utah Administrative Code for the proposed health facility/agency license requested. PLEASE ALLOW 60 DAYS AFTER SUBMISSION FOR COMPLETION OF THE INITIAL REVIEW. ADDITIONAL TIME MAY BE REQUIRED TO REVISE THE SUBMITTED POLICY AND PROCEDURE MANUAL BEFORE RECEIVING BUREAU APPROVAL.

D. APPLICATION.

Submit completed application form, licensing fees, and all required clearances to the Bureau.

E. ONSITE INSPECTION.

Schedule a date with the Bureau to conduct an onsite prelicense inspection. Allow at least five days after policy and procedure manual approval for receiving the inspection.

THE FACILITY/AGENCY MAY NOT BEGIN OPERATION UNTIL A LICENSE IS ISSUED.

Bureau of Licensing - Health Facility Unit
PO Box 142003
Salt Lake City, Utah 84114-2003
Telephone No. (801) 538-6152

Licensing Orientation Meeting Schedule

The Bureau has organized a licensing orientation meeting for anyone interested in obtaining a license to operate a health care facility or home health or hospice agency in Utah. Attendance at this meeting is required as part of the licensing application process. The information presented will outline the Bureau's role and responsibilities in the licensing process and the responsibilities of the owner and operator of a health care facility, hospice or home health agency.

The orientation meeting is held once each month:

- On specified Wednesday mornings starting at:

  9:00 a.m. for Home Health Agencies, Hospices, and Mammography Facilities or other facilities interested in Medicare/Medicaid certification; and
  10:30 a.m. for Assisted Living Facilities, Nursing Care Facilities, ESRD's, Ambulatory Surgical Facilities, Hospitals or other Facilities requiring construction.

Location:

Martha H. Cannon Health Building
288 North 1460 West
Salt Lake City, Utah

RESERVATIONS ARE REQUIRED. We regret that since there are various persons making presentations and many items to cover in a limited time frame, **ANYONE ARRIVING LATE WILL HAVE TO MAKE ARRANGEMENTS TO ATTEND ANOTHER SESSION ON ANOTHER DATE.** ***For reservations or more information, call (801) 538-6152 between 8:00 a.m. and 5:00 p.m. Monday through Friday***.

ORIENTATION MEETING SCHEDULE JANUARY 2004 THROUGH DECEMBER 2004

Wednesday, **January 21, 2004**	Wednesday, **July 14**, **2004**
Wednesday, **February 18**, **2004**	Wednesday, **August 18, 2004**
Wednesday, **March 17, 2004**	Wednesday, **September 22, 2004**
Wednesday, **April 21**, **2004**	Wednesday, **October 20, 2004**
Wednesday, **May 12, 2004**	Wednesday, **November 17, 2004**
Wednesday, **June 16**, **2004**	Wednesday, **December 15, 2004**

UTAH HEALTH CARE FACILITY FEE SCHEDULE

Pursuant to Utah State Legislature FY2004 Appropriation Act the following fees are designated for health care facilities.

ANNUAL LICENSE FEES (Effective July 1, 2003) -**$100 Annual Base Fee Plus the Following:** **$200.00 Semi-Annual Base Fee Plus the Following:**	
Hospitals - Non JCAHO	$14.00 per Licensed Bed
Hospitals - JCAHO	$11.00 per Licensed Bed
Freestanding Residential Treatment Facilities	$ 8.00 per Licensed Bed
Nursing Care Facilities	$10.00 per Licensed Bed
Small Health Care Facilities	$10.00 per Licensed Bed
Assisted Living Type I and II	$ 9.00 per Licensed Bed
End Stage Renal Disease Centers ESRDs	$60.00 per Licensed Station
Freestanding Ambulatory Surgery Centers	$1000.00 per Facility
Birthing Centers	$200.00 per Licensed Delivery Room
Abortion Clinics	$200.00 per Licensed Operating Room
Hospice Agencies	$500.00 per Agency
Home Health Agencies	$500.00 per Agency
Satellite (Branch) Fee	$75.00 per Satellite (Branch) per location

ANNUAL CERTIFICATION FEES (Effective July 1, 2002)	
Mammography Facility	$200.00 per Facility

ADDITIONAL FEES:
Late Fees:

1. A Request for Agency Action/License Application form, applicable fees, and clearances shall be filed with the Department 15 days before the existing license expires. Late fees will be assessed if all fees and documentation are not received by the license expiration date as follows**:**

   Within 14 days after expiration of license - 50% of scheduled fee;
   Within 30 days after expiration of license - 75% of scheduled fee.

2. a. New Provider/Change of Ownership Applications: A $500.00 fee will be assessed for services rendered providers seeking initial licensure or change of ownership. This fee will be due at the time of application.

b. Assisted Living Limited Capacity and Small Health Care Facility - Type 'N' New Provider/Change of Ownership Application: A $250.00 application fee will be assessed for services rendered to providers seeking initial licensure or change of ownership. This fee is due at the time of application.

****The fee for each additional license or copy issued to the same facility during the license year will be $75.00.****

A. Plan Review and Inspections Fees

A minimum of two on-site inspections (one before piping and utilities are enclosed and one final inspection). Projects of two or more stories will normally require additional inspections due primarily to construction phasing. The required number of inspections will be mutually determined after the submittal of preliminary drawings. However, an inspection before enclosure of pipes and utilities is required.

Each additional inspection required or each additional inspection requested by the facility shall cost $100.00 plus mileage in accordance with current state rate, for travel to and from the site by the Department representative.

1. Hospitals:

Number of Beds	Plan Review Fee
UP to 16	$ 2000.00
17 to 50	4000.00
51 to 100	6000.00
101 to 200	7500.00
201 to 300	9000.00
301 to 400	10,000.00
over 400	10,000.00 + $20.00 per each additional bed

In the case of complex or unusual hospital plans, the Bureau of Licensing will negotiate with the provider an appropriate plan review fee at the start of the review process based on the best estimate of the review time involved and the standard hourly review rate.

2. Nursing Care Facilities and Small Health Care Facilities:

Number of Beds	Plan Review Fee
UP to 5	$ 650.00
6 to 17	1000.00
17 to 50	2250.00
51 to 100	4000.00
101 to 200	5000.00

3. New Assisted Living Type I and Type II Facilities:

Number of Beds	Plan Review Fee
Up to 5	$350.00
6 to 16	700.00
17 to 50	1600.00
51 to 100	3000.00
101 to 200	4200.00

4. Freestanding Ambulatory Surgical Facilities: $1000.00 per operating room.

5. Birthing Centers, Abortion Clinics, and similar facilities: $250 per service unit.

6. End Stage Renal Disease Facilities: $100.00 per service unit

B. Plan Review Fees for Remodels of Licensed Facilities

The plan review fee for remodeling an area of a currently operating licensed facility that does not involve an addition of beds, operating rooms or service units, or other clinic type facilities:

1. Hospitals and Freestanding Surgery Facilities: $.16 per sq. ft.

2. All others excluding Home Health Agencies: $.14 per sq. ft.

3. Each required on-site inspection: $100.00 plus mileage reimbursement in accordance with the current state rate.

C. Other Plan-Review Fee Policies

1. If an existing facility has obtained an exemption from the requirement to submit preliminary and working drawings, or other information regarding compliance with applicable construction rules, the Department may conduct a detailed on-site inspection in lieu of the plan review. The fee for this service will be $100.00 per inspection plus mileage reimbursement in accordance with the current state rate.

2. A facility that uses plans and specifications previously reviewed and approved by the Department will be charged 60 percent of the scheduled plan review fee.

3. Thirty cents per square foot will be charged for review of facility additions or remodels that house special equipment such as a CAT scanner or linear accelerator.

4. If a project is terminated or delayed during the plan review process, a fee based on services rendered will be retained as follows:

   a. Preliminary drawing review - 25% of the total fee;

   b. Working drawings and specifications review - 80% of the total fee;

   c. If the project is delayed beyond 12 months from the date of the Department's last review, the applicant must re-submit plans and pay a new plan review fee in order to renew the review action.

UTAH DEPARTMENT OF HEALTH, (801) 538-6152
BUREAU OF LICENSING - HEALTH FACILITY UNIT
288 North 1460 West, PO Box 142003
Salt Lake City, Utah 84114-2003

NOTICE OF INTENT

TO ESTABLISH A NEW HEALTH FACILITY OR AGENCY

This is not an application for licensing. The Department will use this information to assist you in the development of your project and to expedite the application process.

A. PROJECT NAME (NOT REQUIRED IF NOT KNOWN):

_____

Proposed Name *Telephone #*

_____

Address

B. CONTACT (OWNER):

_____

Name *Telephone #*

_____

Mailing Address

C. MANAGEMENT GROUP (IF APPLICABLE):

_____ *Name*

Telephone #

_____

Mailing Address

D. CHECK THE FACILITY OR SERVICE YOU INTEND TO PROVIDE:

	Beds		Beds
G Birthing Center	_____	G Small Health Care Facility - Type 'N'	_____
G Ambulatory Surgical Center	_____	G Abortion Clinic	_____
G End Stage Renal Dialysis	_____	G Hospital	_____
G Small Health Care Facility	_____	G Home Health Agency	
G Nursing Care Facility	_____	G Home Health Agency - Personal Care	
G Assisted Living - Type I	_____	G Hospice G Outpatient G Inpatient	
G Assisted Living - Type II	_____		
G Mammography			

G Satellite - Describe Services _____

G Other _____

E. WHAT DO YOU PLAN TO DO? *(Check all that apply /)*

G Construct a new building G Modify a building

G Other _____

F. IF APPLICABLE, LIST PROJECT ARCHITECT

_____

Name *Telephone #*

_____

Mailing Address

G. WHAT IS THE ANTICIPATED OPENING DATE?

REQUEST FOR AGENCY ACTION/ LICENSE APPLICATION

A. IDENTIFYING INFORMATION: *All satellite/branch programs must also fill out Section A.

FACILITY NAME _____ **TELEPHONE#** _____

FACILITY MAILING ADDRESS _____ **FAX #** _____

FACILITY STREET ADDRESS _____ **EMAIL** _____

CITY AND ZIP _____

ADMINISTRATOR _____ **TELEPHONE#** _____

Professional license? Yes ☐ No ☐ Category _____ **Number** _____

EMERGENCY CONTACT PERSON _____ **TELEPHONE#** _____

DATE OF REQUESTED ACTION: FROM _____ **TO** _____

B. ACTION REQUESTED: (Check all that apply T). Application is complete when copies of all items listed are submitted.

Initial License ☐ **(Include fees, fire clearance, certificate of occupancy, zoning, kitchen inspection, CBS initial clearance)**

Annual Renewal ☐ **(Include fees, fire clearance, CBS Renewal form)**

Change Ownership ☐ **(Include agreement, fees, fire clearance, certificate of occupancy, zoning, kitchen inspection, CBS Consent)**

Change Administrator ☐ **(Include name of new administrator, qualifications, fee)**

Change in Location ☐ **(Include fees, fire clearance, certificate of occupancy, zoning, kitchen inspection)**

Change in Name ☐ **(Include fees)**

Change in Capacity ☐ **(Include fees, fire clearance)**

Change in Management ☐

C. TYPE OF FACILITY: (Check appropriate boxes)

☐ **ACUTE HOSPITAL:**

Number of beds Acute _____ **Swing Beds** _____ ***NBICU*** _____ **Other** _____
Type of Emergency Services (Level I - IV) _____
Number of Isolation rooms in Emergency Dept _____
Number of Emergency bays _____ **Level of Nursery Care (Basic, Specialty, Sub-Specialty)** _____

☐ **SATELLITE Type** _____

☐ **SPECIALTY HOSPITAL**

Type _____ ***#of Beds*** _____
Type of Emergency Services (Level I - IV) _____ **Number of Emergency bays** _____
Level of Nursery Care (Basic, Specialty, Sub-Specialty) _____

☐ **NURSING CARE FACILITY # of Beds** _____ **Skilled** _____ **Intermediate** _____ **Secure Unit (yes/no)** _____

☐ **INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED # of Beds** _____

☐ **SMALL HEALTH CARE FACILITY**

Nursing # of Beds _____ **Type 'N' # of Beds** _____ **ICF/MR # of Beds** _____

☐ **ASSISTED LIVING - TYPE I** **# of Beds** _____ **vs # of Apartments** _____

☐ **ASSISTED LIVING - TYPE II** **# of Beds** _____ **vs # of Apts** _____ **Secure Unit (yes/no)# Beds** _____

☐ **AMBULATORY SURG. CENTER** **# of Surgery Rooms** _____

☐ **BIRTHING CENTER** **# of Birthing Rooms** _____

☐ **ABORTION CLINIC** **# of Surgical Rooms** _____

☐ **END STAGE RENAL DISEASE CENTER** **# of Dialysis Stations** _____

☐ **HOME HEALTH AGENCY** **MAIN OFFICE ☐ BRANCH OFFICE ☐**

☐ **PERSONAL CARE AGENCY** **MAIN OFFICE ☐ BRANCH OFFICE ☐**

☐ **HOSPICE** **INPATIENT ☐ OUTPATIENT ☐ BRANCH OFFICE ☐**

D. VARIANCE CONTINUATION / DEEMED STATUS:

Variance Continuation ☐ Identify Rule: _____

Deemed Status☐ Initiation of Deemed status
Date of accreditation: _____ Accrediting Agency: _____
☐ Continuation of Deemed status

E. OWNERSHIP OF FACILITY: Check One T

☐ Individual proprietorship: (Identify Owner name, address, and persons having ownership)

☐ Corporation: (Identify Corporation name, address; Officers by name, title, address and telephone #)

☐ Partnership: (Identify each partner by name, address and telephone #)

☐ LLC: (Identify LLC name, address; Owners by name, title, address and telephone #)

☐ Other: (Describe the ownership arrangement and identify the owner(s) by name, address and telephone #)

_____

_____

_____

_____

F. OPERATION/MANAGEMENT OF THE FACILITY: Check One T

☐ Individual proprietorship: (Identify Owner name, address, and persons having ownership of 10% or more)

☐ Corporation: (Identify Corporation name, address; Officers by name, title, address and telephone #)

☐ Partnership: (Identify each partner by name, address and telephone #)

☐ LLC: (Identify LLC name, address; Owners by name, title, address and telephone #)

☐ Other: (Describe the ownership arrangement and identify the owner(s) by name, address and telephone #)

_____

_____

_____

_____

Provide the name, address, percentage of stock, shares, partnership or other equity interest of each officer, member of the board of directors, trustees, stockholders, partners, or other persons who have greater than 25 percent interest in the facility:

_____

_____

_____

_____

(USE ADDITIONAL PAGES IF NECESSARY)

Each of the persons listed in E and F have attested to the licensee that they:

a) have never been convicted of a felony;

b) have never been found in violation of any local, state, or federal law which arises from or is otherwise related to the individual's relationship to a health care facility; and

c) have not currently or within the five years prior to the date of application had previous interest in a licensed health care facility that has been any of the following:

- **(i) subject of a patient care receivership action;**
- **(ii) closed as a result of a settlement agreement resulting from a decertification action or a license revocation;**
- **(iii) involuntarily terminated from participation in either Medicaid or Medicare programs; or**
- **(iv) convicted of patient abuse, neglect or exploitation where the facts of the case prove that the licensee failed to provide adequate protection or services for the person to prevent such abuse.**

(Pursuant to R432-2-6(3))

G. CERTIFICATION OF UNDERSTANDING:

I _____, as _____
(Name) (Title)

of the above named facility, understand this request constitutes a Request for Agency Action as specified in Utah Code Ann. 63-46b(3) and serves as the formal document upon which a licensing decision will be based. I agree to abide by the rules promulgated by the State of Utah for this category of health care facility and do hereby state that the information provided on this application is true to the best of my knowledge and belief.

I further understand that I am responsible for admitting and retaining only those persons who qualify as defined in the applicable rules and facility policies and procedures. I agree to allow authorized representatives of the Department of Health, upon presentation of proper identification, to enter the facility at any reasonable time without a warrant and to review facility records and documents as necessary to ascertain compliance with State licensing law and rules promulgated by the Health Facility Committee.

_____ _____
Signature **Date**

CERTIFICATE
OF
FIRE CLEARANCE

UTAH DEPARTMENT OF HEALTH
Bureau of Licensing
PO Box 142003
Salt Lake City, Utah 84114-2003
(801) 538-6152 (801) 538-6325 FAX

GENERAL	YES	N	N/A	REMARKS
1. Proper Exits/Stairways/Aisles				
2. Fire Resistive Construction				
3. Smoking Control				
4. Address on Building				
5. Fire Department Access				
6. Evacuation Plan/Training				
7. Certificate of Occupancy (Bldg. Official)				
8. Hydrant Location				
ELECTRICAL				
9. Proper Wiring: Extension Cords				
10. Elec. Shutoff Accessible/Room Labeled				
HOUSEKEEPING				
11. Good Housekeeping				
12. Proper Storage of Haz. Liquids & Gases				
HVAC SYSTEMS				
13. Gas Devices Vented/Adequate Comb.				
14. Combustibles Remote From Open				
15. Boiler/Appliance Safety				
16. Smoke/Control Systems				
PORTABLE EXTINGUISHERS				
17. Current & Tagged				
18. Placement and Type				
EXTINGUISHING/ALARM SYSTEMS				
19. Fire Extinguishing System				
20. Valves (OS&Y-PIV) FDC Location				
21. Fire Alarm System				
22. Hood Systems				
23. OTHER:				

I, the undersigned, am in receipt of a copy of this inspection and am aware of the penalties for non-compliance of any orders listed hereon.

Additional fire regulations may be enforced by Federal, state or local agencies having program authority

This facility meets a reasonable level of fire and life safety.

YES_____ NO_____

_____

FIRE OFFICIAL/TITLE DATE

_____

OWNER/MANAGER

FOLLOW-UP_____